HEALTH & WELLBEING BOARD

Subject Heading:	**Havering End of Life Care Annual Report 2017/18**
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The subject matter of this report deals with the following themes of the Health and Wellbeing Strategy

- ☒ Theme 1: Primary prevention to promote and protect the health of the community and reduce health inequalities
- ☒ Theme 2: Working together to identify those at risk and intervene early to improve outcomes and reduce demand on more expensive services later on
- ☒ Theme 3: Provide the right health and social care/advice in the right place at the right time
- ☐ Theme 4: Quality of services and user experience

SUMMARY

This annual report summarises progress made with the End of Life (EOL) Care in Havering during 2017/18

RECOMMENDATIONS

The Board is asked to note the report and comment on progress made with End of Life Care in Havering during 2017/18

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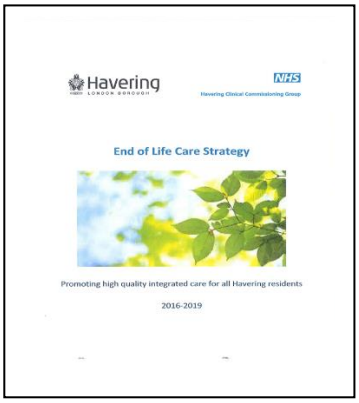
REPORT DETAIL

Havering End of Life Care Update 2017/18

1. Havering End of Life Care Strategy

The Strategy was launched in April 2016. Getting GP practices to develop end of life care plans for patients using the Health Analytics platform has remained our focus. Havering CCG Strategy Action Plan had set a target to develop a rolling average of 500 active care plans by March 2018. We have worked collaboratively with Hospices and EOL Facilitators to genre momentum. This has been achieved.



The strategic objectives of the strategy are:

- Encourage people to discuss death and dying
- Identify all people who are nearing the end of their life
- Have more effective care planning
- A co-ordinated care across health spectrum
- Ensure that all services provide high quality End of Life Care

2. Community Education Provider Networks (CEPN)

CEPNs provide a model for system leadership and infrastructure that individual services would be unable to manage and sustain in isolation. The network allows learning to take place in a range of settings, enabling shared learning and dissemination of best practice around the needs of local populations.

CEPN is establishing a system-wide approach to the management of long term conditions (LTCs) and End of Life Care across the three Clinical Commissioning Groups (CCGs) - Havering, Redbridge and Barking. This will bring key local partners and stakeholders together to identify opportunities for improvement in the management and delivery of LTC and EoL care. Health Education England, have provided resources for local delivery of this programme, through the CEPN.

2.1 Key activities for this work-stream will include the following:

- Establish the current situation in terms of the delivery of care to people with LTCs and in the final year of life - baseline
- Advocate to generate the necessary levels of engagement and commitment to implementing change amongst local providers and commissioners regarding EoL and LTC
- Engage relevant local workforces in identified training provision
- Monitor participation in training focusses on:
    - Understanding and assessing thresholds
    - Engaging in difficult conversations
    - Collaborative care planning
    - Advanced care planning
    - Signposting
    - Advocacy

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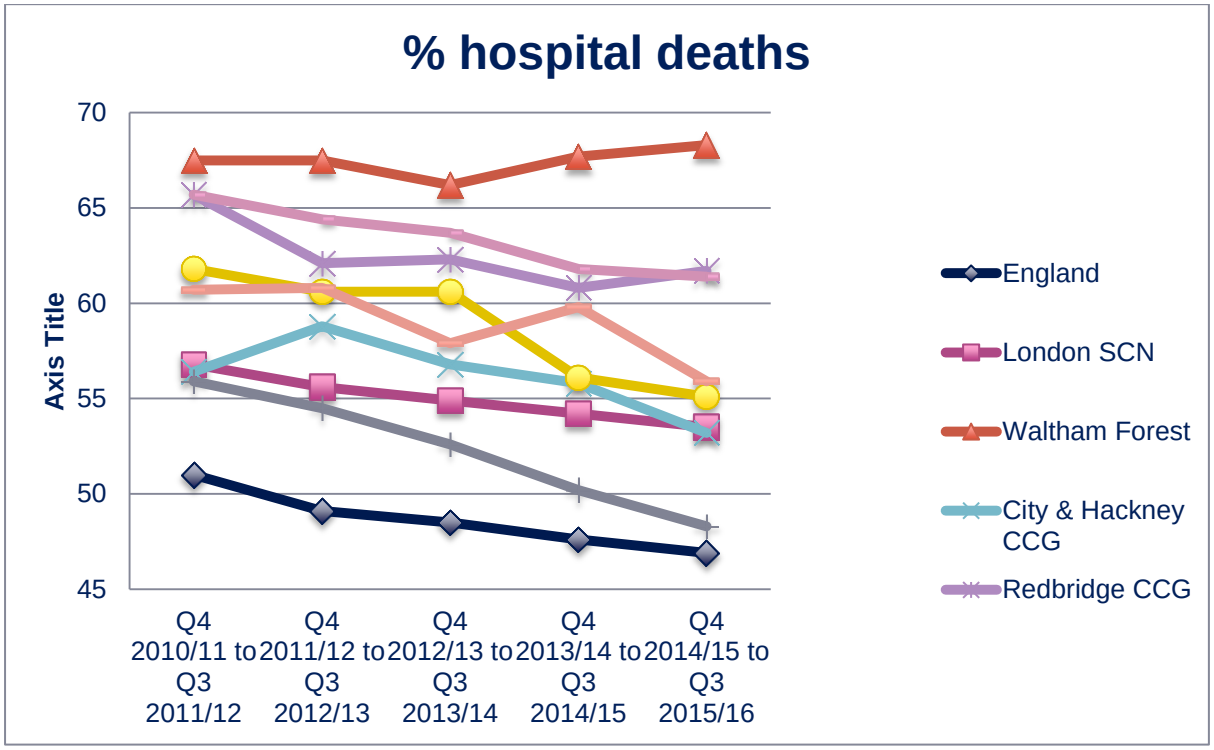
3. Place of Death: Havering achieved highest reduction in deaths in hospital

Havering CCG has made significant progress and has achieved the highest reduction in percentage of deaths in hospital compared to other CCGs in London. The graph below shows that in 2012/13 the number of Havering deaths occurring in hospital was over 56% against the NHS England average of 51% and London average of 57%. Ongoing initiatives and progress made with End of Life Care shows a tremendous downward trend that at present 46% of all deaths for Havering now occur in hospital compared to the London average of 54%.

As a result Havering has received recognition of this achievement at the NEL STP and London levels, and was invited to share best practice at a London Commissioners workshop in February 18.



4. The Framework for Enhanced Health in Care Homes

The NEL STP has adopted the Enhanced Health in Care Homes (EHCH) framework is based on a suite of evidence-based interventions, which are designed to be delivered within and around a care home in a coordinated manner in order to make the biggest difference to its residents. Within this framework one of the priorities is High quality end of life care.

4.1 The EHCH will ensure that it is addressing the needs not only of the individual patients themselves but also of their family, their carers, and their community through:

- Systematic, proactive approach to identify residents who may require end-of-life care.
- Support to die in the persons place of choice ‘advance care planning’, personalised care plans, and treatment escalation plans.
- Use of digital tools such as the electronic palliative care coordination system (EpaCCS) to enhance the quality of end-of-life care.
- Support to care home staff with education and training on palliative care knowledge and skills.

4.2 To deliver the objectives of the EHCH framework, the three BHR CCGs working in collaboration with BHRUT are piloting a scheme in 8 Nursing Care homes; aimed at improving life for care home residents, by ensuring that nursing care home resident's paperwork does not go missing after admission into hospital. The Red Bag contains standardised information about the resident's general health, any existing medical conditions they have, medication they are taking, as well as highlighting the current health concern. This means that ambulance and hospital staff can determine the treatment a resident needs more effectively.

The RedBag also has room for personal belongings (such as clothes for day of discharge, glasses, hearing aid, dentures etc.) and it stays with the patient whilst they are in hospital. When patients are ready to go home, a copy of their discharge summary (which details every aspect of the care they received in hospital) will be placed in the red bag so that care home staff have access to this important information when their residents' arrive back home.

The Red Bag also clearly identifies a patient as being a care home resident and this means that it may be possible for the patient to be discharged sooner, because the care home has been involved in discussions with the hospital and has an understanding of the residents care needs so they are able to support the resident when they are discharged.

If the pilot is successful, the scheme will be extended to all nursing care homes across BHR and later be extended to residential care homes.

5. Electronic End of Life Care Plans

BHR CCGs have adopted Health Analytics as the platform for sharing EOL care plans. Health Analytics is a digital tool (an electronic palliative care coordination system (EpaCCS) to enhance the quality of end-of-life care which was initially developed for information suite to support GP practiced based commissioning.

Plans can be viewed and amended by staff in Primary Care, BHRUT, SFH, and NELFT. Havering have pioneered the use of electronic care plans. This enables systematic Referrals to other relevant services e.g. dementia, Talking therapies, Carers, Cancer and Long-term conditions. As a result Havering CCG agreed a target of 500 EoL Care Plans each year (which represents 20% of expected 1% GP registered population to die each year). As mentioned above, Havering CCG has achieved this target, year on year since 2016/17. Other outcomes associated with electronic EoL care plans include support to patients to achieve their preferred place of death, and reduction avoidable A&E attendance and hospital.

6. BHR End of Life Steering Group

The group meets regularly on a quarterly basis and includes representation from BHR CCGs, London Borough of Havering, London Borough of Barking and Dagenham, London Borough of Redbridge, North East London NHS Foundation Trust (NELFT), North East London Commissioning Support Unit, London Ambulance Service, Partnership of East London Co-operatives (PELC), Marie Curie, St. Francis Hospice, Haven Hospice, Richard Hospice and other stakeholders as required. The Steering group recently merged as a BHR group from previously, a Havering borough EOL steering group. Dr Saini has taken over as chair of the merged group and Clinical Lead for EoL care. Currently the group is aligning the work of the three boroughs more closely to improve collaboration and provision of EoL care.

It is anticipated that the combined BHR EoL Steering Group will highlight and avoid areas of duplication and increase improvement of care for patients. Dr Saini has also highlighted the need for the group to consider EoL care as *a planned care issue*, *from birth to death*, so that all types of patients who are reaching the last stages of their life at any age or any point in time, are appropriately cared for. Havering CCG continues to achieve significant improvements through the steering group.

7. End of Life Service Commissioning

In 2017/18, Commissioners worked with Hospices and the Commissioning Support Unit contracts team to identify gaps and challenges in commissioned services for EOL, and provide solutions going forward. This included transition pathways into adult hospice services, hospice at home and respite care. The BHR CCGs have taken a decision to extend hospice contracts until 2019. Current commissioned services include:

7.1 Marie Curie

One-to-one overnight palliative care to support service users at the end of life and their families in their usual place of residence in Havering and Barking and Dagenham. Service users receive a nine hour working night shift at their preferred place of residency during their last days of life, during which the palliative nursing care and advice is provided as appropriate to address individual service user needs.

7.2 Children's Hospice

BHR CCGs commission **Haven House** in Waltham Forest – Woodford, who provide hospice services for Havering residents.

Services offered include:

- Overnight respite - residential
- Day time support – on/off site
- End of Life Care
- Step down
- A range of other support for the patients and their families

7.3 Saint Francis Hospice

A key shared strategic aim is to ensure that people who are dying and who want to remain at home have the care and support they need to enable them to stay at home. SFH have continued to work in partnership with GPs, District and Community Nurses, social care providers, and people who are poorly, their family, carers and friends to:

- Encourage an opening up of conversations about end of life care, and offer expert education to all in the health and care community
- Provide hands on help through the Hospice at Home team, to support people through this time and prevent unwanted hospital admissions
- Ensure a 24/7 advice and support service for people at home
- Support nursing homes in their support of residents who are now frail and approaching end of life
- Support hospital to home discharges for people at end of life, who want to be at home, who need that extra support to get there
- Support best use of hospice beds for people who are not managing at home, or for whom hospital care is not the right care now.
- SFH have developed services now offering outpatients for doctors, nurses and all AHPs and have a service that reaches out to the isolated - Orangline

8. Conclusion

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Whilst good progress has been made with End of Life care in Havering there are still areas that need further development. We need to reach out to BAME communities to enable access to commissioned EoL care. A plan is being developed to pull together common themes across BHR and we are working with the NEL STP leads to achieve this.

IMPLICATIONS AND RISKS

End of Life Care has ceased to be specifically managed by the Havering CCG locality and is part of a BHR wide programme, but the aims of the programme will be maintained.

BACKGROUND PAPERS

None